WISCONSIN LEGISLATURE
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Assembly Committee on Aging and Long Term Care and
Senate Committee on Public Health, Human Services, and Revenue
Assembly Bill 302 and Senate Bill 212
State Representative Dan Knodl and State Senator Pam Galloway
October 13, 2011

First, we would like to thank the Chairperson and members of the committees for attending this hearing to discuss how we as a state can strengthen our nursing homes.

To continue our tradition of quality in Wisconsin, our offices worked with stakeholders on both sides of this issue to answer the question, how can we continue to provide quality nursing home care in Wisconsin? Our solution involved giving the Department of Health Services greater flexibility with their existing enforcement tools, creating a board of stakeholders to direct money for improvement programs, cleaning up the regulatory systems, and stopping the practice of dual penalties.

To address the subject of greater flexibility, this bill allows DHS to use citations issued by the federal government as standing to use their various state enforcement tools. These tools include the issuing a conditional or probationary license to a violating nursing home, and even suspending admissions of new applications to the home.

Second, under current law, the Federal Government sends back a portion of the fines it collects to the state. Our bill would allow DHS to distribute these moneys for innovative projects that aim to improve the safety and welfare of nursing homes residences. These projects would be reviewed by a board of quality assurance and improvement to ensure maximum effectiveness.

This bill also contains many recommendations from a 2002 Legislative Audit Bureau report on nursing homes. Our bill streamlines the process of appeals to allow nursing homes to consolidate hearings on a notice of finding and a notice of forfeiture into one. It also removes the indefinite timeline DHS has to issue a forfeiture following a notice of violation.

Last, but not least, our bill addresses the issue of "dual enforcement." Currently, nursing homes can be fined twice, once by the state, and once by the Federal Government, for the exact same violation. In many cases, the language on the notice of finding is lifted from the federal one. Having two sets of enforcement standards has impeded our ability to improve nursing home quality, creating a double-jeopardy scenario that causes a facility

to receive two different forfeitures for the same violation. This bill would only prohibit DHS from issuing a citation if the home were cited for the same citation under federal regulations. This provision does not "deregulate" nursing homes or in any way weaken state regulations.

This legislation has bipartisan support in the Assembly and in the Senate, in addition to numerous advocacy groups. We all recognize the importance our nursing homes play, and this bill will help maintain this commitment.

We would like to thank the committee for their time and we would be happy to entertain any questions that you may have.

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

Testimony of Otis L. Woods
Division Administrator for the Division of Quality Assurance
Wisconsin Department of Health Services

Public Hearing on AB 302 and SB 212

Senate Committee on Public Health, Human Services, and Revenue
Assembly Committee on Aging and Long-Term Care

October 13th, 2011

Chairperson Galloway, Chairman Knodl, and other distinguished members of the committee, thank you for allowing me to speak at today's hearing on the proposed changes to the Department's enforcement of our state's nursing home regulations. I am Otis Woods, administrator of the Division of Quality Assurance (DQA) within the Department of Health Services. The Division of Quality Assurance (DQA) is responsible for the regulation and licensing of 46 health care and residential programs in Wisconsin that provide acute health care, long-term care, assisted living care, mental health and substance abuse services, and caregiver background checks and investigations.

Today I will be providing information on the potential impact of Assembly Bill 302 and Senate Bill 212 on the regulatory environment of Wisconsin's nursing homes. This legislation amends certain provisions in Wisconsin Statutes, Chapter 50, affecting the regulation of nursing homes.

Currently there are 398 nursing homes licensed in Wisconsin caring for over 32,000 of our state's most vulnerable residents, the elderly and those with various disabilities. Wisconsin law provides protection for these individuals under Chapter 50 of the State Statutes. All nursing homes in Wisconsin are required to be licensed and comply with the state's licensure rule, Wisconsin Administrative Code for Nursing Homes, Chapter DHS 132.

Nursing homes that choose to participate in the Medicaid or Medicare programs and receive federal funding must comply with federal nursing home regulations and are subject to federal enforcement remedies. In Wisconsin; all but 5 nursing homes are federally certified. The provisions in AB 302 and SB 212 primarily affect nursing homes that are federally certified.

The Department of Health Services, Division of Quality Assurance (DQA), is responsible for assuring the health, safety, and welfare of residents in Wisconsin's nursing homes. To accomplish this goal, the Division of Quality Assurance conducts an unannounced survey every 9 to 15 months, with an average of 12 months, of all nursing homes, checking for compliance with state and federal nursing home regulations. The survey process is outcome oriented and relies heavily on interviews with residents and their families to determine both the quality of care and the quality of life provided by the nursing home and resident satisfaction with the services the nursing home provides.

Under current law, a federally certified nursing home is subject to both state and federal nursing home regulations and enforcement remedies. Nursing homes that commit a serious violation, one that harms a resident or seriously threatens the resident's health or safety, usually receive a state violation and a federal citation for the exact same incident. Violations of state code are eligible for a forfeiture or monetary fine. Chapter 50 allows the Department to assess up to $5,000 per day for any violation that directly threatens the health and safety of a resident and up to $10,000 per day for any violation that results in the substantial probability of death or serious harm to a resident. The purpose of a forfeiture is two-fold, 1) to penalize a facility for violating the rule and, 2) to act as a deterrent to prevent a similar violation from occurring in the future.

In 2010, the Department issued 19 Class A violations and 470 Class B violations against nursing homes in Wisconsin. Currently, any dollars collected from these forfeitures cannot be used to retrain staff who erred or even to improve the quality of care in Wisconsin's nursing homes – which is, ultimately, our main mission.

Under the proposed legislation, the Department will be prohibited from issuing a violation of the state requirements and imposing a state sanction if the nursing home was cited for a violation of a federal requirement based on the same facts. The only violations of state code that the Department will issue are violations of codes that have no matching federal regulation. Ultimately, if a federal citation is issued, no state citation can be issued for the same facts. Under the proposed bills, the Department estimates that there will be fewer than 5 serious violations of state codes issued against nursing homes with less than $10,000 issued in forfeitures annually.

When the Department confirms violations of federal regulations, the federal government, through the Centers for Medicare and Medicaid Services, issues remedies. This is unlike state enforcement action in that a nursing home may be given an opportunity to correct a deficiency (citation) before a remedy goes into effect. Federal remedies include civil money penalties, directed inservice training, denial of payment for new admissions, etc. DQA recommends potential remedies but the federal government implements said remedies.

Examples of the use of federal Civil Money Penalties for innovative projects have included:

1. *Establishment of the Wisconsin Clinical Resource Center, in concert with the trade associations and the University of Wisconsin, Madison, to provide immediate access to up-to-date standards of practices for various clinical conditions to all Wisconsin nursing homes; This has become a national model to which access from across the nation is being requested.*

2. *Expanding and enhancing the relocation ombudsman program at the Board On Aging and Long Term Care to provide advocacy services to nursing home residents when facilities close or downsize to ensure that residents continue to receive quality care during a difficult transition period in their lives.*

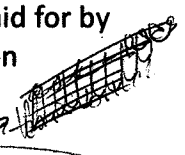
3. *Certifying approximately 250 registered nurses in Wisconsin nursing homes on the prevention, care and treatment of pressure ulcers, or bed sores. This is a process we hope, soon, to replicate.*

4. *Establishing the Wisconsin Pressure Ulcer Coalition, a collaboration of members from home care, assisted living, acute care and long-term care to prevent the development of pressure ulcers through improvement in communication and sharing of information as consumers transition between environments of care.*

5. *Approving funds to pilot innovative care practices regarding the care, treatment and access to on-site psychiatric intervention for resident suffering with Dementia or Alzheimer's disease to prevent admission to inpatient psychiatric facilities.*

6. *Expanding the use of information technology in nursing homes through a wireless nurse call system.*

Effective January 1st , 2012, the Center for Medicare and Medicaid services will have an increased participatory role in the review, approval, or denial of innovative quality improvement projects paid for by Civil Money Penalties. CMS is modeling their program to mirror the program that has already been established in Wisconsin.



The proposed legislation amends the statute to allow the Department to use violations of federal regulation to support several state licensure actions taken against poor or marginal nursing homes. AB 302 and SB 212 give the Department authority to use federal citations to suspend or revoke a license or issue a conditional license. Under the current law, the Department is not able to use federal violations to support state actions. The Department will also be able to consider substantial or repeated violations of federal nursing home regulation in determining whether to issue a probationary license, transfer the ownership of a facility, place a monitor in the facility, appoint a receiver or take over operations of a nursing home.

Another component of the proposed legislation allows the Department to use federal civil money penalties (CMP) to fund innovative projects that are designed to improve the quality of life, care and treatment of nursing home residents. Similar provisions are currently available in the Administrative Code for Nursing Homes, Chapter DHS 132. The proposed legislation would place the committee requirements, which are currently in rules, into the state statute. Since creating the committee, DHS has awarded hundreds of thousands of dollars for innovative care practices designed to improve the quality of life and quality of care to all nursing home residents in Wisconsin.

This program has been very successful in advancing and improving the care-delivery systems in Wisconsin's nursing homes.

There are other, less significant, provisions in the proposed legislation such as imposing a time limit on the Department to complete a forfeiture assessment and allowing more time, 60 days instead of 10 days, for a facility to file an appeal of a violation or forfeiture. The proposed legislation would also give the Department discretion to not issue a citation in cases where the nursing home took reasonable efforts to prevent the violation but the violation still occurred and the facility corrected the violation promptly. These changes will streamline the regulatory process, increase the effectiveness of Wisconsin's oversight program, and have little impact on Wisconsin's nursing home residents. This proposal was recommended by the Legislative Audit Bureau following a 2002 audit of the Department's oversight of nursing homes.

Wisconsin's nursing home oversight program relies heavily on onsite surveys and prompt investigations of complaints to assess whether the appropriate quality of care and quality of life is being provided.

The Department is committed to continuously improving the quality of care provided by nursing facilities. In addition to its vigorous inspection and enforcement program, the Department is working with nursing home representatives and the advocacy community in a number of unique ways to enhance service and protect the health, safety and welfare of nursing home residents.

Wisconsin's nursing homes rank high nationally on quality indicator reports issued by the federal government. The ongoing collaboration with nursing homes and advocates will continue to place an emphasis on quality improvement methods that will innovate nursing home care in Wisconsin.

Thank you for this opportunity to provide information on the Department's oversight of the 398 Wisconsin nursing homes. I would be happy to entertain any questions that you may have at this time.

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TESTIMONY
For Information Only

Of Heather A. Bruemmer; Executive Director
Of the Wisconsin Board on Aging and Long Term Care
Before the Assembly Committee on Aging and Long Term Care and
The Senate Committee on Public Health, Human Services and Revenue
13 Oct 2011

Chairpersons Knodl and Galloway, members of the Committees, thank you for holding this joint hearing on AB 302. The Board on Aging and Long Term Care (BOALTC), at this time, expresses neither its support nor opposition to this piece of legislation.

AB 302 has been characterized as a substantially re-worked version of 2003 AB 842 affecting the regulatory system for assuring quality in nursing homes. The current version of the bill was thoroughly reviewed and commented on by representatives of the long term care provider groups, the Department of Health Services' Division of Quality Assurance and the BOALTC, on behalf of our constituents – Wisconsin's nursing home residents, prior to being sent to the drafters. The collaborative input of these parties represents a sincere effort on their part to focus change where it will do the most good for the residents.

Created by Chapter 20 of the Laws of 1981, the Board on Aging and Long Term Care is charged with the mandate to advocate for individuals aged 60 and over who, all too often, are unable to speak for themselves and left without another voice to speak for them. Residents of long term care facilities, specifically including nursing homes, are a particular area of emphasis. Our agency's Long Term Care Ombudsman Program, mandated in federal law by the Older Americans Act at 42 USC 3058g as incorporated by reference into state law at §16.009(4)(a), Stats., is charged with providing direct and systemic advocacy for this group.

Our decision not to raise objections to the language of AB 302 as currently drafted is based on our belief that the current system of long term care facility regulation is not working effectively for our residents. Sadly, the severity and frequency of citations for significant lapses in the quality of care and the safety and well-being of our state's residents who live in nursing homes has not diminished in recent memory. The Department of Health Services has data indicating horrible examples of poor care of residents, of overt abuse of residents, and of failure to protect residents who are unable to protect themselves.

The regulatory system that Wisconsin has in place to assure nursing home residents that they will be safe and well-cared-for needs improvement. This is evident because the system all too often identifies instances of significant harm to the residents of poor performing nursing homes. This bill represents an attempt to fix that regulatory system. AB 302 is an acknowledgement of the fact that there are problems with the current system and the bill is an effort to restructure that system into something that will provide not only penalties for regulatory violations, but also effective incentives for facilities to deliver the care that our seniors and disabled individuals deserve.

The bill retains substantial penalties along with a more structured process for helping providers and others obtain and utilize the tools to develop and implement quality improvement programs.

The Board on Aging and Long Term Care is not willing to hang on to the existing system simply because no one has offered a guaranteed remedy to the problems that we are now seeing. Wisconsin needs to innovate and to alter the system of assuring that providers deliver quality care to residents. We are certain that AB 302 will not eliminate all traces of poor care from our long term care facilities, but we need to attempt some form of positive change.

We urge the members of this committee to carefully consider the comments that you hear today, and to make your decisions based not on the passion displayed by the witnesses, but on the impact that failure to positively change the regulatory system will have on the residents of our nursing homes.

Wisconsin Association of Homes and Services for the Aging, Inc.

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October 13, 2011

To: Senator Pam Galloway, Chair
Members, Senate Public Health, Human Services, and Revenue Committee
Representative Dan Knodl, Chair
Members, Assembly Aging and Long-Term Care Committee

From: John Sauer, Executive Director

Subject: 2011 Senate Bill 212/Assembly Bill 302: The "Strengthening our Nursing Homes Act"

By way of introduction, my name is John Sauer and I serve as the Executive Director of the Wisconsin Association of Homes and Services for the Aging (WAHSA), a statewide membership association of 200 not-for-profit/ governmental long-term care organizations serving older adults and persons with a disability.

The long-term care provider community has been working with officials from the Department of Health Services (DHS) and the Board on Aging and Long-Term Care (BOALTC) to develop legislation which would amend Chapter 50, Wis. Stats., to prohibit the DHS Division of Quality Assurance (DQA) from issuing a notice of violation (NOV) of a State nursing home requirement to a Medicaid- or Medicare-certified nursing facility if the DQA also has issued a statement of deficiency (SOD) to that same facility for a violation of a federal nursing home requirement that is based on the same facts ("dual enforcement").

That proposal has been introduced as companion bills: 2011 Senate Bill 212 and Assembly Bill 302, the "Strengthening our Nursing Homes Act." **We urge your support for this legislation.**

SB 212/AB 302 also would amend s. 50.04(4)(a) 2a-b to make it permissive for the DQA either to cite or not to cite a nursing facility for a violation that was self-reported by the facility to the DQA if the facility either has corrected the violation or has made every reasonable effort to prevent and correct the violation but the violation has occurred and remains uncorrected due to circumstances beyond the facility's control. Under current law, the DQA is required to issue a notice of violation to a facility which self-reports a violation if the facility has corrected the violation, while oddly it is permitted not to cite a facility only if the violation remains uncorrected due to circumstances beyond the facility's control.

ISSUE: The DHS is under contract with the federal Centers for Medicare and Medicaid Services (CMS) to conduct compliance surveys (inspections) of each federally-certified (Medicaid and/or Medicare) Wisconsin nursing home every 9-15 months and to enforce federal nursing home regulations. At the same time, the DHS is responsible for surveying each nursing home licensed under Chapter 50, Wis. Stats., every 9-15 months and for enforcing State nursing home regulations under Chapter 50 and DHS 132, Wis. Adm. Code. Both federal and state surveys are conducted simultaneously by DQA staff.

Violations of **federal** nursing home regulations are classified both by their severity and scope. The four "severity" categories are:

1. Harm Level 1: No actual harm with potential for minimal harm;
2. Harm Level 2: No actual harm with potential for more than minimal harm that is not immediate jeopardy ("Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.");
3. Harm Level 3: Actual harm that is not immediate jeopardy; and
4. Harm Level 4: Immediate jeopardy to resident health or safety.

The federal violations also are classified into three "scope" categories: 1) Isolated; 2) Pattern; and 3) Widespread. An enforcement remedy or sanction is applied to each of the 12 "scope & severity" categories. The federal enforcement remedies/sanctions that may be imposed to address these violations include the following: directed plan of correction; state monitor; directed in-service training; denial of payment for new admissions; denial of payment for all Medicaid/Medicare residents; temporary management; termination from the Medicaid and/or Medicare programs; and civil money penalties (CMP) ranging from $50 to $10,000 per day or from $1,000 to $10,000 per instance of noncompliance. A copy of the federal "scope and severity" grid, as well as the remedies available for each level of violation, is attached.

There are three classifications of **State** nursing home violations:

1) A Class "A" violation is a violation of Chapter 50 and/or DHS 132 "which creates a condition or occurrence relating to the operation and maintenance of a nursing home presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom." (s. 50.04(4)(b)1). A Class "A" violation may be subject to a forfeiture of not more than $10,000 per day of violation.(s. 50.04(5)(a)1);
2) A Class "B" violation is a violation of Chapter 50 and/or DHS 132 "which creates a condition or occurrence relating to the operation and maintenance of a nursing home directly threatening to the health, safety or welfare of a resident." (s. 50.04(4)(b)2). A Class "B" violation may be subject to a forfeiture of not more than $5,000 per day of violation. (s. 50.04(5)(a)2); and
3) A Class "C" violation is a violation of Chapter 50 and/or DHS 132 "which creates a condition or occurrence relating to the operation and maintenance of a nursing home which does not directly threaten the health, safety or welfare of a resident." (s. 50.04(4)(b)3). A Class "C" violation may be subject to a forfeiture of not more than $500 per day of violation and is only imposed if the violation is a repeat violation or if the facility fails to correct the violation by a specified date. (s. 50.04(5)(a)3a and b).

Under current law, State violations also may subject a nursing facility to State licensure actions such as suspension or revocation of license, suspension of admissions, conditional license and/or triple forfeitures.

A nursing home can be cited under current law for a violation of both federal and state statute or code that is based on virtually the same facts and circumstances. SB 212/AB 302 would prohibit the issuance of a state violation if a federal violation already has been issued

for the same noncompliant activity. Of equal importance are the bills' provisions to permit the DHS to use certain federal deficiencies issued against a facility, as well as state violations, for possible State licensure actions against that facility.

RATIONALE FOR THE SB 212/AB 302 "DUAL ENFORCEMENT" LEGISLATION

- DQA surveyors often must issue both federal and state citations for the same violation. Indeed, most state citations are copied verbatim from the federal statement of deficiency. This form of "dual enforcement" is regulatory excess and overly punitive, while not contributing to quality improvement. The purpose of this legislation is to prohibit the DQA from issuing a State nursing home citation if a federal citation already has been issued for the same violation.

- WAHSA recently conducted a survey of its state association affiliates across the country to determine how many other states operate a "dual enforcement" system similar to the one currently operating in Wisconsin. While only 8 states responded (Minnesota, Iowa, Illinois, Indiana, Ohio, California, North Carolina and Oklahoma), **none operate a similar "dual enforcement" system.** In those States, a state violation is cited only when there is no federal regulation applicable to a deficient practice. That is the approach we seek to take in SB 212/AB 302.

- According to the DHS, there were 35 Class "A" and 410 Class "B" state violations issued with a matching federal deficiency and a state forfeiture assessment in 2008, the last year this data was available.

- The intent of this legislation is to improve quality of care in Wisconsin nursing homes by focusing regulatory attention on compliance rather than punishment. The primary difference between the federal and state regulatory and enforcement systems is the federal system applies enforcement remedies/sanctions only after a facility fails to come into compliance with federal requirements. The federal focus is on compliance. **The State regulatory system also focuses on compliance but is more punitive in nature because sanctions are imposed even if compliance is achieved and because the primary State sanction is a forfeiture assessment which cannot be used by the facility for quality improvement purposes.**

- Nursing home care is labor intensive: 73-cents of every dollar spent by a nursing home are for labor-related costs. If you reduce nursing home revenues by imposing monetary penalties, staffing almost certainly will be impacted and reduced staffing could jeopardize resident care.

- The DQA contract with CMS requires all federal nursing home violations to be cited. As noted above, the federal enforcement system has a wide array of remedies/sanctions. Which begs the question: What is the need for this "dual enforcement" system? If an act or omission of a nursing home violates State law but not federal law, a highly unusual circumstance, the full force of State enforcement sanctions remains available to hold a

provider accountable. How will quality care in a nursing home be enhanced by issuing a state violation, with corresponding sanctions, when federal violations/sanctions already have been issued or compliance already has been achieved?

- If this "dual enforcement" system for nursing homes were applied to speeding tickets, speeding on the Capitol Square could result in the issuance of separate moving violations by the Madison Police Department, the Dane County Sheriff's Department, the Capitol Police and possibly the State Patrol.

- This proposal would not "deregulate" nursing homes or weaken state regulations. It simply would guarantee regulatory compliance without subjecting facilities to a state-federal "double whammy" for the same violation.

- According to the DHS, 149 nursing facilities, or 41% of the state's total, were operating at a net loss in 2008. Since that time, the average Wisconsin nursing home received a rate reduction of 0.7% in FY 2011. That average facility loses $37.71 per day for each Medicaid resident it serves, for an average annual Medicaid loss of $782,000. Most facilities attempt to offset their Medicaid losses by serving the Medicare population; however, Medicare rates for skilled nursing facilities were reduced on average by 12.6% effective October 1, 2011. Assessment of a state forfeiture to a nursing home with shaky finances, especially when compliance already has been achieved, truly is piling on, especially since state forfeitures cannot be used for quality improvement by the violating facility.

- There is no empirical evidence that the State's use of monetary penalties or other punitive measures are effective quality improvement and compliance tools. Indeed, for those facilities at financial risk, the opposite would appear to be true.

Citing Self-Reports: SB 212/AB 302 also seeks to address a quirk in current law. Under s. 50.04(4)(a)2, the DHS is not required to cite a nursing home if the nursing home self-reports a violation to the DHS and the nursing home has made every reasonable effort to prevent and correct the violation, but the violation occurred and *remains uncorrected* due to circumstances beyond the nursing home's control. The DHS has interpreted this language to mean that if a facility self-reports a violation to the DHS and corrects the violation, the DHS is required to issue a citation to the facility. This makes virtually no sense and we have created language in Section 10 of SB 212/AB 302, in concert with the DHS, to rectify that situation.

SB 212/AB 302 also includes these additional provisions:

1. **Assessment of Forfeitures:** Under current law, there is no time limit for the DHS to assess a state forfeiture for a violation. In some instances, over a year has gone by between the issuance of a notice of violation (NOV) and a forfeiture assessment. SB 212/AB 302 amends s. 50.04(5)(c) to require the DHS to assess a state forfeiture within

120 days of issuing a NOV to a facility or the Department loses its authority to assess the forfeiture.

2. **NOV/Forfeiture Assessment Appeals:** Under current law, a nursing facility has 10 days to file an appeal after receiving a NOV or a forfeiture assessment. SB 212/AB 302 amends s. 50.04(4)(e)1 and s. 50.04(5)(e) to extend that appeal time limit to 60 days, as recommended by the Legislative Audit Bureau in its December 2002 report (Report 02-21) *Regulation of Nursing Homes and Assisted Living Facilities*. The additional time to consider an appeal request actually may reduce the number of appeals as it will allow facilities the opportunity to more carefully review and consider options rather than simply file an appeal request as a defense mechanism. The proposal also amends s. 50.04(5)(e) to permit a consolidated hearing if a facility chooses to appeal both a NOV and the forfeiture assessment issued as a result of that NOV.

3. **Forfeiture Assessment Payments:** Under SB 212/AB 302, s. 50.04(5)(f) would be amended to require all forfeiture assessments to be paid to the DHS within 60 days, rather than 10 days, of the receipt of forfeiture assessment notice or, if the forfeiture is appealed, within 60 days, rather than 10 days, after receipt of the final decision after exhaustion of administrative review. In addition, the proposal amends s. 50.04(5)(fm) which permits the DHS to reduce the amount of a forfeiture payment by 35% to a nursing facility which chooses not to appeal a NOV, not to appeal a forfeiture assessment for either a Class "A" or a Class "B" state violation and pays the forfeiture assessment within 60 days, rather than the 10 days under current law, after receipt of the forfeiture assessment notice.

4. **Conditional Licensure:** Under current law, the DHS can impose a conditional license on a nursing facility that has not corrected a Class "A" or a Class "B" state violation. SB 212/AB 302 recreates s. 50.04(6)(a)1 to permit the DHS to also impose a conditional license on a nursing facility for a continuing violation of federal law that constitutes immediate jeopardy or actual harm not involving immediate jeopardy to a resident.

5. **Use of Federal Compliance for State Licensure:** SB 212/AB 302 amends s. 50.03(4m)(a) to require nursing facilities not previously licensed in Wisconsin to comply not only with state licensure requirements but with federal regulations as well in order to transform their probationary licenses into regular nursing home licenses.

6. **Suspended Admissions:** SB 212/AB 302 amends s. 50.04(4)(d)1a and 1b to allow the DHS to suspend admissions to a nursing home not only for certain violations of state law but also for certain violations of federal requirements.

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership association of 200 not-for-profit or governmental long-term care organizations which own, operate and/or sponsor 183 nursing homes, 136 assisted living facilities and 113 senior housing complexes. WAHSA members employ over 38,000 dedicated staff which provide care and services to over 48,000 residents, tenants and/or clients. For further information, contact WAHSA Executive Director John Sauer (jsauer@wahsa.org) or Director of Government Relations Tom Ramsey (tramsey@wahsa.org) at 608-255-7060. Effective 1-1-12, WAHSA will be changing its name to ***LeadingAge Wisconsin*** *to more formally align with its affiliated not-for-profit national association, LeadingAge.*

home shall correct the class "C" violation by the date specified in the correction order or the extended date, if granted.

1r. The department may serve a notice of violation on a nursing home determined to be in violation of this subchapter or the rules promulgated under it for a class "C" violation if either of the following conditions apply:

a. The nursing home fails to make a correction by the date specified in a correction order served under subd. 1g. b. or by an extension of the date, if granted.

b. The violation is a class "C" repeat violation, regardless of whether a correction order has first been served.

2. The department is not required to serve a notice of violation if each of the following conditions exists:

a. The nursing home brings the violation to the department's attention.

b. The nursing home has made every reasonable effort to prevent and correct the violation, but the violation occurred and remains uncorrected due to circumstances beyond the nursing home's control.

3. The department is not required to serve a notice of a class "C" violation if it finds that the nursing home is in substantial compliance with the specific rule violated.

(b) *Classification of violations.* 1. A class "A" violation is a violation of this subchapter or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a nursing home presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom.

2. A class "B" violation is a violation of this subchapter or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a nursing home directly threatening to the health, safety or welfare of a resident.

3. A class "C" violation is a violation of this subchapter or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a nursing home which does not directly threaten the health, safety or welfare of a resident.

4. Each day of violation constitutes a separate violation. Except as provided in sub. (5) (a) 4., the department shall have the burden of showing that a violation existed on each day for which a forfeiture is assessed. No forfeiture may be assessed for a condition for which the nursing home has received a variance or waiver of a standard.

(c) *Correction.* 1. The situation, condition or practice constituting a class "A" violation shall be abated or eliminated immediately unless a fixed period of time, as determined by the department and specified in the notice of violation, is required for correction. If the class "A" violation is not abated or eliminated within the specified time period, the department shall maintain an action in circuit court for injunction or other process against the licensee, owner, operator, administrator or representative of the facility to restrain and enjoin violation of applicable rules, regulations and statutes.

2. At the time of issuance of a notice of a class "B" or "C" violation, the department shall request a plan of correction which is subject to the department's approval. The nursing home shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction but the department may extend this period up to 30 days where correction involves substantial capital improvement. The plan shall include a fixed time period within which violations are to be corrected. If the nursing home plan of correction is substantially in compliance, it may be modified upon agreement between the department and the nursing home to achieve full compliance. If it rejects a plan of correction, the department shall send notice of the rejection and the reason for the rejection to the nursing home and impose a plan of correction. The imposed plan of correction may be modified upon agreement between the department and the nursing home.

3. If the violation has been corrected prior to submission and approval of a plan of correction, the nursing home may submit a report of correction in place of a plan of correction. Such report shall be signed by the administrator under oath.

4. Upon a licensee's petition, the department shall determine whether to grant a licensee's request for an extended correction time. Such petition must be served on the department prior to expiration of the correction time originally approved. The burden of proof is on the petitioner to show good cause for not being able to comply with the original correction time approved.

5. This paragraph does not apply to notices of violation served under par. (a) 1r.

(d) *Suspension of admissions.* 1. The department shall suspend new admissions to a nursing home if all of the following apply:

a. The nursing home received notices of violation for a class "A" violation or 3 or more class "B" violations in the previous 12 months.

b. The nursing home received notices of violation for a class "A" violation or 3 or more class "B" violations in any 12–month period during the 3 years immediately preceding the period specified in subd. 1. a.

2. A suspension of admissions under subd. 1. shall begin 90 days after a nursing home received its last notice of violation for a class "A" or class "B" violation if the department determines that the violation remains uncorrected 90 days after the nursing home received the last notice of the violation. If the nursing home indicates to the department that the violation has been corrected, but the department is unable to verify that the violation has been corrected, a suspension of admissions under subd. 1. shall begin on the day that the department makes a return visit to the nursing home and determines that the violation has not been corrected. A suspension of admissions under subd. 1. shall remain in effect until the department determines that all class "A" and class "B" violations by the nursing home have been corrected. Admission of a new resident during the period for which admissions have been suspended constitutes a class "B" violation.

3. In determining whether subd. 1. applies, the department may not consider a notice of violation found to be unjustified after hearing.

4. If the department suspends new admissions to a nursing home under this paragraph, the department shall publish a class 1 notice under ch. 985 in a newspaper likely to give notice in the area where the nursing home is located.

(dm) *Inspection fee.* If the department takes enforcement action against a nursing home, including an intermediate care facility for the mentally retarded, as defined in 42 USC 1396d (d), for a violation of this subchapter or rules promulgated under it or for a violation of a requirement under 42 USC 1396r, and the department subsequently conducts an on–site inspection of the nursing home to review the nursing home's action to correct the violation, the department may, unless the nursing home is operated by the state, impose a $200 inspection fee on the nursing home.

(e) *Hearings.* 1. If a nursing home desires to contest any department action under this subsection, it shall send a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1) within 10 days of receipt of notice of the contested action. Department action that is subject to a hearing under this subsection includes service of a notice of a violation of this subchapter or rules promulgated under this subchapter, a notation in the report under sub. (3) (b), imposition of a plan of correction and rejection of a nursing home's plan of correction, but does not include a correction order. Upon the request of the nursing home, the division shall grant a stay of the hearing under this paragraph until the department assesses a forfeiture, so that its hearing under this paragraph is consolidated with the forfeiture appeal hearing held under sub. (5) (e). All agency action under this subsection arising out of a violation, defi-

SCOPE / SEVERITY/HARM	ISOLATED *(One or a very limited number of residents affected and/or one or a very limited number of staff involved, and/or the situation occurred only occasionally or in a very limited number of locations.)*	PATTERN *(More than a limited number of residents affected, and/or more than a limited number of staff involved, and/or the situation occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same practice.)*	WIDESPREAD *(Situation was pervasive throughout the facility or represented a systemic failure that affected or had the potential to affect a large portion or all of the facility's residents.)*
(4) Immediate jeopardy to resident health or safety *(Deficient practice caused or is likely to cause serious injury, serious harm, serious impairment or death AND there is a reasonable degree of predictability of a similar situation occurring in the future. Immediate corrective action is needed.)*	J	K	L
(3) Actual harm that is not immediate jeopardy *(Deficient practice led to a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being...)*	G	H	I
(2) No actual harm with potential for more than minimal harm that is not immediate jeopardy *(Deficient practice has led to minimal physical, mental, and/or psychosocial discomfort to the resident and/or a yet unrealized potential for compromising the resident's ability to maintain and/or reach his/her highest practicable level of physical, mental, and/or psychosocial well-being...)*	D	E	F
(1) No actual harm with potential for no more than minimal harm *(Deficient practice has the potential for causing no more than minor negative impact on residents.)*	SUBSTANTIAL COMPLIANCE A	SUBSTANTIAL COMPLIANCE B	SUBSTANTIAL COMPLIANCE C

SHADED AREAS = SUBSTANDARD QUALITY OF CARE for any deficiency in s. 483.13 Resident Behavior and Facility Practices (F221-F225), s. 483.15, Quality of Life (F240-F258), and s. 483.25 Quality of Care (F309-F333).

*** If the examples under one tag are at different levels of harm, choose the HIGHEST harm level and the scope associated with that particular level of harm.

Health Bulletin

A Supplement to Washington Report

American Association of Homes and Services for the Aging
901 E Street NW, Suite 500, Washington, DC 20004-2037 • (202)783-2242 • FAX (202)783-2255

January 23, 1995

Nursing Facility Enforcement: Selection of Remedies

This *Health Bulletin* is one of a series designed to prepare AAHSA members for the changes to be implemented by the nursing facility survey, certification and enforcement final regulation July 1.

In an earlier *Health Bulletin* (Nov. 23, 1994), we had noted that in order to give guidance to survey agencies on selection of remedies to be applied for various deficiencies, HCFA has developed three categories of remedies linked to the degree of noncompliance. HCFA has organized the remedies from least to most severe, and has specified the deficiencies to which they should apply.

Enforcement Remedies

The remedies available for nursing facility enforcement are:

- Directed plan of correction*
- Directed inservice training*
- Denial of payment for new admissions
- Denial of payment for all individuals
- State monitoring
- Civil money penalties
- Temporary management
- Termination
- Closure in emergency situations and/or transfer.

* *These sanctions were created by HCFA; all others were specified in OBRA 1987.*

Severity and Scope

All deficiencies will be classified through the use of severity and scope, according to the following scales:

Severity

- Immediate jeopardy to resident health or safety
- Actual harm that is not immediate jeopardy
- No actual harm with potential for more than minimal harm that is not immediate jeopardy
- No actual harm with potential for minimal harm.

Scope

- Isolated
- Pattern
- Widespread.

Factors in Selecting Remedies

In addition to severity and scope, other factors to be considered in choosing a remedy include but are not limited to: (1) the relationship of one deficiency to other deficiencies resulting in noncompliance and (2) the facility's prior history of noncompliance in general and specifically regarding the cited deficiencies.

Categories of Remedies

Remedies described above are grouped into categories and applied to remedies according to how serious the noncompliance is.

Category 1 Remedies

- Directed plan of correction
- State monitoring
- Directed inservice training.

These remedies are applied when: (1) there are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy or (2) there is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

Category 2 Remedies

- Denial of payment for new admissions
- Denial of payment for all individuals imposed only by HCFA
- Civil money penalties of $50 to $3,000 per day.

These remedies are applied when: (1) there are widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy or (2) there are one or more deficiencies that constitute actual harm that is not immediate jeopardy.

–MORE–

Category 3 Remedies

- Temporary management
- Immediate termination
- Civil money penalties of $3,050 to $10,000 per day.

When there are one or more deficiencies that constitute immediate jeopardy to resident health or safety, HCFA or the state must impose temporary management or terminate the provider agreement, and also may impose Category 3 level fines. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, HCFA or the State may impose temporary management, in addition to other Category 2 remedies. A nursing facility must submit a plan of correction for each deficiency, except for isolated deficiencies that constitute no actual harm with a potential for minimal harm.

The application of categories of remedies to various types of deficiencies is illustrated with the chart below. The chart provides plans of corrections (POC) based on the scope and severity of the deficiency.

Categories of Remedies To Be Applied to Deficiencies

	ISOLATED	PATTERN	WIDESPREAD
IMMEDIATE JEOPARDY TO RESIDENT HEALTH OR SAFETY	PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2
ACTUAL HARM THAT IS NOT IMMEDIATE JEOPARDY	PoC Required: Cat. 2 Optional: Cat. 1	PoC Required: Cat. 2 Optional: Cat. 1	PoC Required: Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
NO ACTUAL HARM WITH POTENTIAL FOR MORE THAN MINIMAL HARM THAT IS NOT IMMEDIATE JEOPARDY	PoC Required: Cat. 1 Optional: Cat. 2	PoC Required: Cat. 1 Optional: Cat. 2	PoC Required: Cat. 2 Optional: Cat. 1
NO ACTUAL HARM WITH POTENTIAL FOR MINIMAL HARM	No PoC No Remedies Commitment to Correct Not on HCFA-2567	PoC	PoC

■ Substandard quality of care: any deficiency in §483.13 Resident Behavior and Facility Practices, §483.15 Quality of Life, or §483.25 Quality of Care that constitutes: immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance: a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

Sheboygan Senior Community
930 N. 6th St.
Sheboygan, WI 53081

To: Senator Pam Galloway, Chair
Members, Senate Public Health, Human Services and Revenue Committee
Representative Dan Knodl, Chair
Members, Assembly Aging and Long Term Care Committee

From: Joan Kleist, RN, Director of Operations
Sheboygan Senior Community

Date: October 13, 2011

Subject: Amendment of Chapter 50, Wis. Stats.

I would like to begin by presenting 2 true and actual "dual enforcement" situations that we at Sheboygan Senior Community have personally experienced.

On 5-20-2010, a Resident who had a high risk of falling, had interventions in place to help prevent falls. A Certified Nursing Assistant failed to follow the Resident's care plan and did not assure the interventions were in place. This resulted in the Resident falling and obtaining minor injuries. An occurrence of this kind could be viewed as neglect, therefore, we are required to investigate the situation and send in a "self-report" to the DQA—which we did.

After the Resident fell, we immediately took care of him, assured the interventions were put in place, investigated the situation, reeducated and disciplined the CNA. Reeducation of the rest of the staff was done as well and audits followed to assure a reoccurrence didn't happen.

Because we sent in the self-report, the State Surveyors came into our Facility on 7-19-10 (two months later) to investigate the situation themselves. The DQA gave us a Federal cite for not following the Resident's care plan and also gave a State Class B cite for the same thing. We had not tried to hide the fact that the situation happened. We sent in the self-report as required.

We totally took care of the situation before the Surveyors arrived two months later and still were punished for it and not only once but twice. I wrote the Plan of Correction for the Federal cite and repeated it for the State Class B cite.

We received the forfeiture for this State Class B cite on 12-14-2010 , 7 months after the occurrence. The forfeiture was $1912.50.

In April of 2011, during our Annual Recertification Survey, we received a Federal citation regarding the treatment and prevention of Pressure Ulcers. This because the regulation states a Resident is not to develop Pressure Ulcers while in the Facility unless it can be proven it is unavoidable. A Resident had a very small pressure area that we were not aware of. The Resident pointed it out to the Surveyor during an interview.

Again, we received a Federal cite for a Resident developing a pressure ulcer and also received a State Class B cite for this same violation. I wrote the Plan of Correction for the Federal cite and again repeated it exactly the same for the State Class B cite.

We received the forfeiture for this State Class B cite on 9-8-2011, 5 months after the occurrence. The forfeiture was $1440.00.

In all cases such as this, no additional care is provided and no additional changes are made in our delivery of care whether we receive only a Federal cite or if a State Class B is given along with it.

Dual Enforcements are strictly punitive.

Dual Enforcements are very costly, time consuming and very demoralizing for the staff. $3300+ may not sound like a lot of money but when you take into consideration we lose $44.36 per day for each Resident covered by Medicaid which amounts to an annual loss of $585,286 and you also take into consideration that we just experienced a Medicare cut on October 1 which will amount to an annual loss of $427,967 for our Facility....with more cuts possibly coming....we simply can't afford this.

We have always had staffing numbers higher then the norm but with the acuity of the Residents continuing to rise and reimbursement being cut, it makes it much more difficult to staff at levels needed to provide quality care. Completing Plans of Corrections takes approximately 7-9 days. This doesn't include the 5 days it takes to thoroughly complete an investigation, the approximately 4-5 days to retrain all employees and approximately another 2-3 days to complete the remaining items in these types of situations. All this time spent for something that really doesn't do anything to improve the quality of care we give our Residents.

When cites are "piled on" it creates a very negative image of a Facility in the Resident's, Family's and the Public's eyes. It gives the illusion that a Facility has a greater number of areas of violation then they actually do.

All Facilities have areas of noncompliance at one time or another. We don't deny that or try to hide that. Being that we are humans caring for humans, mistakes will be made. All of us have the same goal—to provide good quality care for very vulnerable people. It is absolutely necessary for surveyors to assure that care is of adequate quality and when we need to be held accountable for noncompliance, we accept that as well. However, what other industry holds their workers accountable by punishing them twice for the exact same thing?

Thank you for allowing me to share my experiences with you. We hope those experiences have convinced you of the necessity to amend Chapter 50, Wis. Stats., to prohibit dual enforcement.

Independent Living Council
OF WISCONSIN

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October 13, 2011

To: Representative Daniel Knodl, Chair
Assembly Committee on Aging and Long-Term Care
Senator Pam Galloway, Chair
Senate Committee on Public Health, Human Services, and Revenue

From: Ben Barrett, Chair
Independent Living Council of Wisconsin

Re: AB 302 / SB 212 – Nursing Facility Regulation

The primary purpose of the Independent Living Council of Wisconsin is to plan for services throughout Wisconsin to support the Independence of people with disabilities. There may be no issue as important to people with disabilities as the availability of a safe home with quality services to support our disability-related needs.

People get into nursing facilities when they have a chronic health condition for which they need long-term support. This often happens when their family is no longer able to support them at home or there is a breakdown in support they receive due to a provider going out of business or some other reason.

The legislator has enacted two bills significantly impacting on people who need these services. The first, Wisconsin Act 2, limits the ability of nursing facility residents who are injured or killed and their families to sue for damages. The second, Act 32 is forcing more people into facilities. Act 32 does this by capping community long-term care services and requiring DHS to find additional Medicaid savings.

The Department recently released its ideas for Medicaid savings. These include significant cuts to personal assistance services and other supports people rely upon for community living.

AB 302 and SB 212 are introduced within this context. After weakening private enforcement of safety for nursing facility residents and forcing more people into these facilities, these bills would weaken governmental protection of the safety and health of facility residents. Two provisions of these bills are most worrisome.

AB 302 and SB 212 do this primarily by restricting the ability of quality assurance surveyors to seek remedies under both state and federal rules. Forcing a choice makes the job of surveyors more difficult. It also reduces the potential liability for operating a facility unsafely and/or unhealthily.

The second way these bills weaken protections is by giving facilities cited for maintaining unsafe conditions sixty days to pay or appeal instead of ten. Facilities with unsafe conditions must fix the problem immediately to protect their residents. Giving them longer to pay or appeal cuts against this message.

People often go to nursing facilities to die. We must not allow moderators to hasten that end. These bills send the wrong message

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TO: Members of the Senate Committee on Public Health, Human Services, and Revenu and Members of the Assembly Committee on Aging and Long-Term Care

FROM: Debora B. Klatkiewicz, NHA Administrator of Personnel and Regulations
Park Manor Ltd.

RE: Assembly Bill 302/Senate Bill 212 "Strengthening Our Nursing Homes Act"

October 13, 2011

Thank you for the opportunity to speak with you today. My purpose here involves the provisions of this proposed legislation discussing "double jeopardy" or dual citing of both state and federal nursing home regulations for the same alleged deficient practice.

Personal Background:

- Thirty-one (31) years experience in long term care at Park Manor Nursing Home, the last eighteen (18) as Administrator of Personnel and Regulations.
- Fifteen (15) years on the Wisconsin Health Care Association Board including five (5) years as President. Extensive networking and contact with peers in the nursing home profession.
- An almost unnatural interest in regulations and regulatory compliance.
- I list my background not to be self-serving, but rather credible.

Survey Process:

- Extensive surveys are held within a nine to fifteen month window for all licensed nursing homes, with in-depth review of all services and care provided to the residents.
- Alleged deficiencies in regulatory compliance are identified, and cited accordingly. Current practice includes often citing both state and federal deficiencies for the same allegation of non-compliance. Moderate to higher level deficiencies with an allegation of a potential for harm are also assigned significant monetary penalties, one for the state deficiency and one for the federal deficiency.
- Each deficiency requires a thorough plan of correction addressing the residents or system named, other residents or systems that may be affected, education of staff, and quality assurance or follow-up to assure continued compliance. Again, these are generally identical for the state and federal deficiency.
- If the facility determines that the alleged deficiencies are baseless, state and federal appeals can take years and are financially challenging, even when the outcome is positive. The cost of one hour of an attorney is equivalent to four or five registered nurses. With apologies to attorneys, I believe the nurse time more directly benefits the residents.

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Outcome:

- Facilities strive and struggle to achieve and maintain regulatory compliance throughout the year and especially in response to citing of deficiencies. There is no question that the residents entrusted to our care deserve no less.
- However, duplication of deficiencies does nothing to promote resident care but rather even further deplete facility scarce resources. Duplication of fines is simply wrong, no matter how one looks at it. The often cited example in the real world relates to a motorist being ticketed for speeding by both local and county law enforcement for the same offense.
- I speak both for Park Manor and for my peers in the Wisconsin Health Care Association, who have shared with me for years and at length their trials and tribulations regarding this practice. Nursing home financial resources are scarce. These resources should be applied to resident care and improvement of that care, not toward double fines that really help no one. The average survey at Park Manor (average of one hundred residents) takes approximately 150 hours of surveyor time at the facility and approximately 400 to 500 hours of staff time including response to the statement of deficiencies, education, resident assessment, etc. Believe me, surveys get our attention.

Federal versus state regulations:

Wisconsin has a long history of dedication and concern for residents receiving care in nursing homes. Long before federal regulations were compiled in 1987, Wisconsin had a booklet of regulation firmly in place.

Federal regulations are far more prescriptive and detailed in nature. Picture five inches of paper for the feds versus one-half inch for the state. Federal regulations are in a state of revision and flux, addressing and updating vital areas of resident care all well known to the public – infection control, wounds, hydration, nutrition, etc., etc., etc. Relying on these regulations as a "first" line of compliance will not in any way diminish or dilute the care provided nursing home residents.

Conclusion:

I have attached a copy of an Executive Summary of a national "scoreboard" on long term care compiled by AARP, The Commonwealth Fund, and the Scan Foundation. In this summary, on page ES-2, Wisconsin is ranked fifth in the country and in the top quartile under "Quality of Life and Quality of Care". The dedication of the State of Wisconsin – caregivers, regulators, and legislators – is well known and respected. This legislation in its entirety promotes that dedication and reputation while bringing fairness back to the table. Thank you in advance for your support.

Respectfully,

Debora B. Klatkiewicz

Debora B. Klatkiewicz, NHA

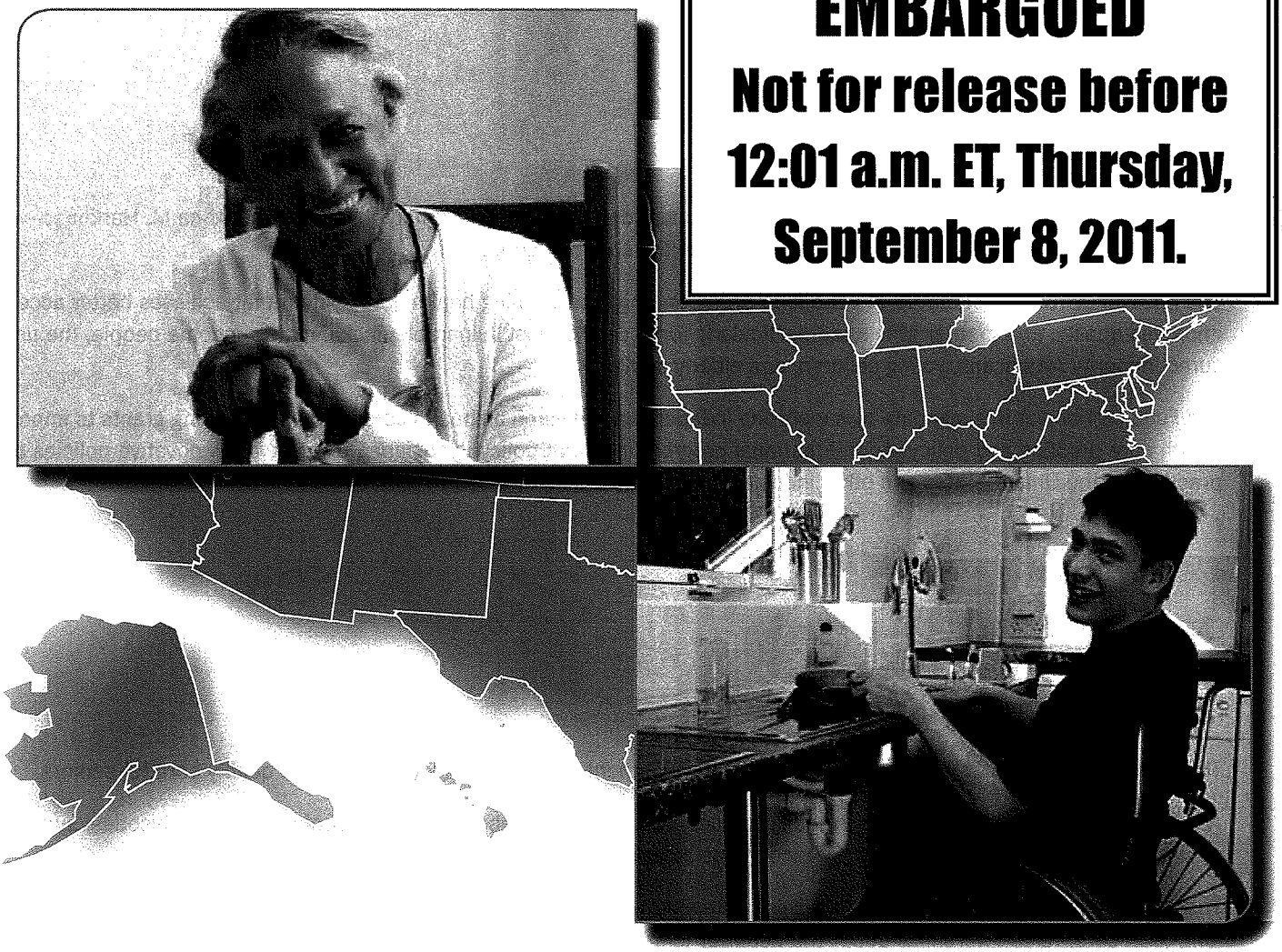
Raising Expectations: EXECUTIVE SUMMARY

A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers

Susan C. Reinhard, Enid Kassner, Ari Houser, and Robert Mollica

September 2011

EMBARGOED
Not for release before 12:01 a.m. ET, Thursday, September 8, 2011.



AARP®
THE COMMONWEALTH FUND
THE scan FOUNDATION.

For more than 50 years, AARP has been serving its members and society by creating positive social change.

AARP's mission is to enhance the quality of life for all as we age, leading positive social change, and delivering value to members through information, advocacy, and service.

We believe strongly in the principles of collective purpose, collective voice, and collective purchasing power. These principles guide our efforts.

AARP works tirelessly to fulfill the vision: a society in which everyone lives their life with dignity and purpose, and in which AARP helps people fulfill their goals and dreams.

THE COMMONWEALTH FUND

The Commonwealth Fund, among the first private foundations started by a woman philanthropist–Anna M. Harkness–was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

THE SCAN FOUNDATION.

The SCAN Foundation's mission is to advance the development of a sustainable continuum of quality care for seniors.

A sustainable continuum of care improves outcomes, reduces the number and duration of acute care episodes, supports patient involvement in decision making, encourages independence, and reduces overall costs.

The SCAN Foundation will achieve this mission by encouraging public policy reform to integrate the financing of acute and long-term care, raise awareness about the need for long-term care reform and work with others to promote the development of coordinated, comprehensive and patient-centric care.

Support for this research was provided by AARP, The Commonwealth Fund, and The SCAN Foundation. The views presented here are those of the authors and do not necessarily reflect the views of the funding organizations nor their directors, officers, or staff.

PHOTO CREDITS: Cover: Top, iStock. Bottom, Fotosearch. embar

EXECUTIVE SUMMARY

This *State Long-Term Services and Supports Scorecard* is the first of its kind: a multidimensional approach to measure state-level performance of long-term services and supports (LTSS) systems that provide assistance to older people and adults with disabilities. Analysis of the "starter set" of indicators included in this report finds that performance varies tremendously across the states with LTSS systems in leading states having markedly different characteristics than those in lagging states. Yet even the top-performing states have some opportunities for improvement. In general, the states at the very highest levels of performance have enacted public policies designed to:

- improve access to needed services and choice in their delivery by transforming their Medicaid programs to cover more of the population in need and offer the alternatives to nursing homes that most people prefer;
- facilitate access to information and services by developing effective "single point of entry" systems so that people who need services can find help easily; and
- address the needs of family caregivers by offering legal protections as well as the support and services that can help prevent burnout.

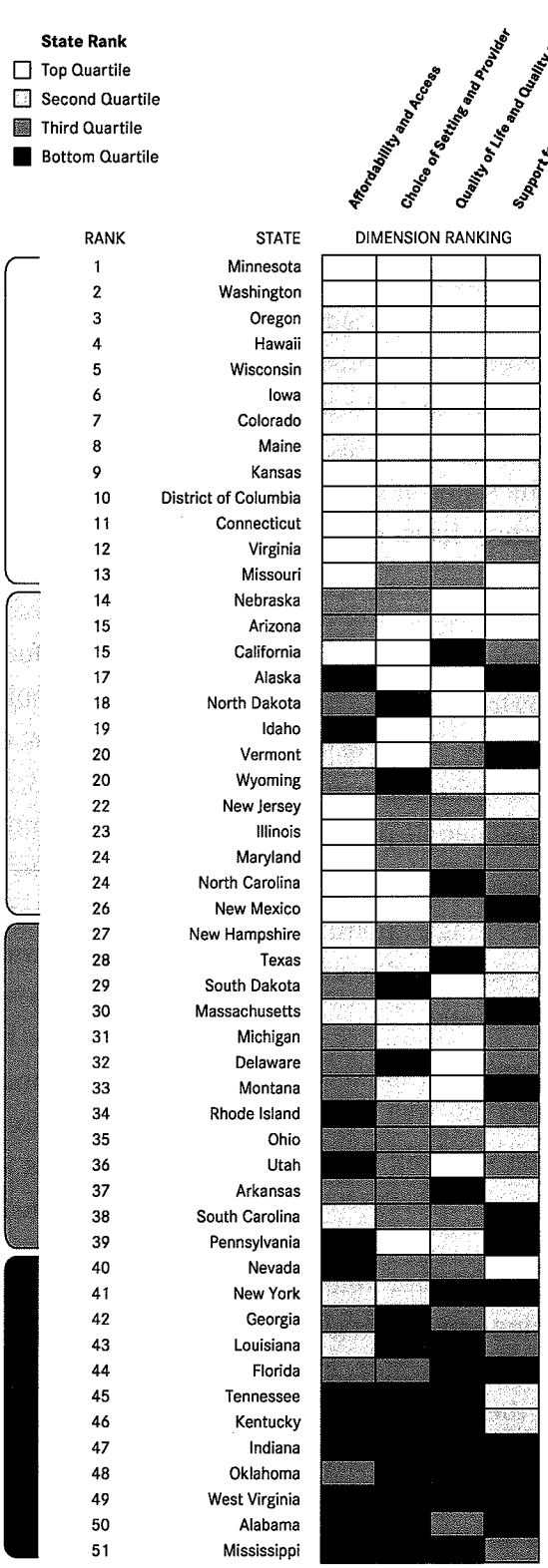
Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Its role is especially critical because the cost of services exceeds the ability to pay for most middle-income families. Even in the most "affordable" states, the cost of nursing home care exceeds median income for the older population. Thus, states need to take action to ensure that alternatives to nursing homes are available, an effective safety net helps people who are not able to pay for care, and family caregivers, who provide the largest share of help, receive the support they need. States also have a leading role to play in ensuring that the LTSS delivered in all settings are of high quality. But public policy is not the only factor affecting state LTSS performance: actions of providers and other private sector forces affect state performance either independently, or in conjunction with the public sector.

The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being. Our intention is that this *Scorecard* will begin a dialogue among key stakeholders so that lagging states can learn from top performers and all states can target improvements where they are most needed. Furthermore, we hope that the *Scorecard* will underscore the need for states to develop better measures of performance over a much broader range of services and collect data in order to more comprehensively assess the adequacy of their LTSS systems.

The *Scorecard* examines state performance across four key dimensions of LTSS system performance, developed in consultation with a team of expert advisors: (1) affordability and access; (2) choice of setting and provider; (3) quality of life and quality of care; and (4) support for family caregivers. Exhibit 1

Exhibit 1

State Scorecard Summary of LTSS System Performance Across Dimensions



Source: State Long-Term Services and Supports Scorecard, 2011.

illustrates each state's overall ranking as well as its quartile of performance in each of the four dimensions. These four dimensions align with the characteristics of a high-performing LTSS system as recently articulated by the authors in *Health Affairs*.[1] We identified a fifth dimension, coordination of LTSS with medical services, which is also critically important but were unable to create indicators to measure that dimension with currently available data. Indeed as we discuss below, one of the more noteworthy "findings" of our work on the *Scorecard* is how much we are not able to compare because information on quality, experiences, coordination, costs, or outcomes is simply not available. Information is critical to guide and inform improvement. We hope that this *LTSS Scorecard* will spark future federal and state action.

Within the four dimensions, the *Scorecard* includes 25 indicators. Exhibit 2 lists the indicators that compose each dimension and shows the range of performance across the states for each indicator. While some of the indicators rely on data that have been reported elsewhere, many represent new measures. Several indicators are constructed from a range of data in a related area, facilitating the ability to rank states in areas of performance that are difficult to assess. As such, the findings differ from analyses that examine a single aspect of states' LTSS systems, such as the "balance" of public services provided in home- and community-based settings compared to nursing homes. This multidimensional analysis involves a richer exploration of data to assess performance, thereby capturing state performance across a complex range of system characteristics.

Major Findings

The states that ranked at the highest level across all four dimensions of LTSS system performance, in order, are Minnesota, Washington, Oregon, Hawaii, Wisconsin, Iowa, Colorado, and Maine.

Leading states often do well in multiple dimensions—but all have opportunities to improve

The leading states generally score in the top half of states across all dimensions. Public policy decisions made in these states interact with private sector actions, resulting in systems that display higher performance. But no state scored in the top quartile across all 25 indicators, demonstrating that every state LTSS system has at least one indicator on which it trails the standards set by top states. Even within dimensions, there is only one instance in which a state ranked in the top quartile across every indicator in the dimension.

Poverty and high rates of disability present challenges

Lagging states scored in the bottom half of states on most dimensions. Among the states in the bottom quartile overall (Mississippi, Alabama, West Virginia, Oklahoma, Indiana, Kentucky, Tennessee, Florida, Louisiana, Georgia, New York, and Nevada), many are in the South, and have among the lowest median incomes and highest rates of both poverty and disability in the nation. This pattern largely holds across all dimensions. Among southern states, only Virginia and North Carolina rank in the top half overall. See Exhibit 3 for the geographic pattern of overall LTSS system performance.

Exhibit 2

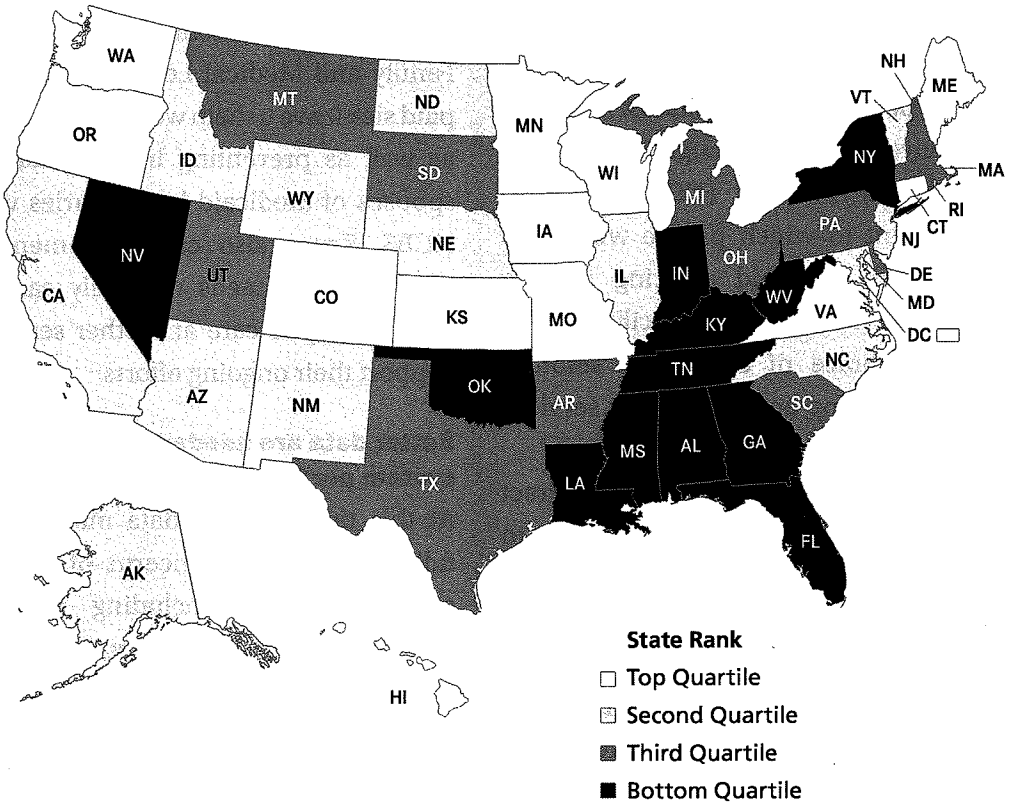
List of 25 Indicators in State Scorecard on Long-Term Services and Supports System Performance

	Dimension and Indicator	Year	All States Median	Range of State Performance (bottom–top)	Top State
	Affordability and Access				
1	Median annual nursing home private pay cost as a percentage of median household income age 65+	2010	224%	444%–166%	DC, UT
2	Median annual home care private pay cost as a percentage of median household income age 65+	2010	89%	125%–55%	DC
3	Private long-term care insurance policies in effect per 1,000 population age 40+	2009	41	28–300	ME
4	Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance	2008–09	49.9%	38.7%–63.6%	ME
5	Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community	2007	36.1	15.9–74.6	MN
6	ADRC/Single Entry Point functionality (composite indicator, scale 0–12)[a]	2010	7.7	1.0–11.0	MN
	Choice of Setting and Provider				
7	Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities	2009	29.7%	10.5%–63.9%	NM
8	Percent of new Medicaid LTSS users first receiving services in the community	2007	49.9%	21.8%–83.3%	MN
9	Number of people consumer-directing services per 1,000 adults age 18+ with disabilities	2010	8.0	0.02–142.7	CA
10	Tools and programs to facilitate consumer choice (composite indicator, scale 0–4)[a]	2010	2.75	0.50–4.00	IL, PA
11	Home health and personal care aides per 1,000 population age 65+	2009	34	13–108	MN
12	Assisted living and residential care units per 1,000 population age 65+	2010	29	7–80	MN
13	Percent of nursing home residents with low care needs	2007	11.9%	25.1%–1.3%	ME
	Quality of Life and Quality of Care				
14	Percent of adults age 18+ with disabilities in the community usually or always getting needed support	2009	68.5%	61.3%–78.2%	AK
15	Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life	2009	85.0%	80.2%–92.4%	SD
16	Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64	2008–09	24.2%	17.6%–56.6%	ND
17	Percent of high-risk nursing home residents with pressure sores	2008	11.1%	17.2%–6.6%	MN
18	Percent of long-stay nursing home residents who were physically restrained	2008	3.3%	7.9%–0.9%	KS
19	Nursing home staffing turnover: ratio of employee terminations to the average number of active employees	2008	46.9%	76.9%–18.7%	CT
20	Percent of long-stay nursing home residents with a hospital admission	2008	18.9%	32.5%–8.3%	MN
21	Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients	2010	90%	77%–97%	HI
22	Percent of home health patients with a hospital admission	2008	29.0%	40.2%–21.8%	UT
	Support for Family Caregivers				
23	Percent of caregivers usually or always getting needed support	2009	78.2%	71.0%–84.0%	OR
24	Legal and system supports for caregivers (composite indicator, scale 0–12)[a]	2008–10	3.17	0.50–6.43	OR
25	Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks)	2011	7.5	0–16	CO, IA, MO, NE, OR

[a] Composite indicators combine information on multiple policies and programs; see Appendix B2 for detail.
Notes: See Appendix B2 for data year, source and definition of each indicator. ADL = Activities of Daily Living; ADRC = Aging and Disability Resource Center; HCBS = Home and Community-Based Services.
Source: State Long-Term Services and Supports Scorecard, 2011.

Exhibit 3

State Ranking on Overall LTSS System Performance



Source: State Long-Term Services and Supports Scorecard, 2011.

Many states have opportunities to improve

States that ranked in the second quartile (Nebraska, Arizona, California, Alaska, North Dakota, Idaho, Vermont, Wyoming, New Jersey, Illinois, Maryland, North Carolina, and New Mexico) all scored in the top quartile on at least one dimension. With the exception of Alaska (an unusual state because of its unique geography), no state in the second quartile scored in the bottom quartile on more than one dimension. These states all have areas of success, and can also improve to a higher level of performance by targeting their efforts in areas where they lag, and where other states have shown the path to higher performance.

Wide variation exists within dimensions and indicators

Wide variation exists within all dimensions, with low-performing states being markedly different from those that score high. In many cases, low-performing states have not adopted public policies that increase access to services or that enable consumers to exercise choice and control. Substantial variations also are found in the quality of service delivery and in measures of support for family caregivers.

State Medicaid policies dramatically affect consumer choice and affordability

Medicaid is the primary source of public funding for LTSS. It plays a leading role in determining the extent to which low-income older people, people with disabilities, and their families receive support through home- and community-based services (HCBS). It also affects the extent to which people with LTSS needs who want to avoid entering nursing homes are able to do so, by facilitating or hindering the choice of alternative settings, such as assisted living and supportive services in the home.

This is an area over which states have direct control, and some states have led the way to improve access and choice in Medicaid. These policy decisions are reflected in the proportion of Medicaid LTSS spending that states devote to HCBS and their success in supporting new program participants' choice of HCBS, as opposed to nursing homes.

Support for family caregivers goes hand in hand with other dimensions of high performance

The *Scorecard* reports on assistance for family caregivers by assessing whether they are receiving needed support and by examining state laws that can aid caregivers. But the most meaningful support for caregivers is a better overall system that makes LTSS more affordable, accessible, and higher quality, with more choices. Thus, high state scores on access, affordability, and choice may reflect states' recognition that caregivers are essential and policies that aid them include building a strong overall system. Very few states that score highly on support for family caregivers score poorly on other dimensions, and few states that score poorly on the caregiving dimension are ranked in the top quartile overall.

States can improve their performance by exceeding the federal requirements for the Family and Medical Leave Act and mandating paid sick leave to help working family caregivers, as well as preventing impoverishment of the spouses of Medicaid beneficiaries who receive HCBS. States also can implement programs to assess the needs of family caregivers and provide respite care and other services to help support their ongoing efforts.

Better data are needed to assess state LTSS system performance

At this time, limited data make it difficult to fully measure key concerns of the public and of policymakers, including the availability of housing with services, accessible transportation, funding of respite care for family caregivers, and community integration of people with disabilities. Improving consistent, state-level data collection is essential to evaluating state LTSS system performance more comprehensively. Most critically, an important characteristic of a high-performing LTSS system identified by the *Scorecard* team—how well states ensure effective transitions between hospitals, nursing homes, and home care settings and how well LTSS are coordinated with primary care, acute care, and social services—cannot be adequately measured with currently available data.

It is our hope that improved data collection will enable future *Scorecards* to expand upon the strong set of foundational indicators in this initial *State LTSS Scorecard* and provide a more complete and comprehensive analysis of LTSS system performance in the future.

The cost of LTSS is unaffordable for middle-income families

The cost of services, especially in nursing homes, is not "affordable" in any state. The national average cost of nursing home care is 241 percent of the average annual household income of older adults. Even in the five most affordable states, the cost averages 171 percent of income, and in the least affordable states it averages an astonishing 374 percent. When the cost of care exceeds median income to such a great degree, many people with LTSS needs will exhaust their life savings and eventually turn to the public safety net for assistance.

Though less extreme, the cost of home health care services also is unaffordable for the typical user, averaging 88 percent of household income for older adults nationally. People who receive home care services must add these costs to all their other living expenses. If they cannot afford the home care services they need, they may place added burdens on family caregivers who most likely already are providing services.

Impact of Improved Performance

States can improve their LTSS system performance in numerous ways. Improvement to levels achieved by top-performing states would make a difference to the 11 million older people and adults with physical disabilities who have LTSS needs,[2] and their family caregivers, in terms of access, choice, and quality of care. For example:

- If all states' public LTSS safety nets were as effective as that of Maine in covering low-income people with disabilities, an additional 667,171 individuals would receive coverage through Medicaid or other public programs. Such coverage would link people with disabilities and limited incomes to health care as well as long-term services and supports.
- States that effectively inform people with LTSS needs about home and community care options and offer an array of service choices can address the preferences of consumers in a cost-effective manner. If all states rose to Minnesota's level of performance on this measure, 201,531 people could avoid costly and unnecessary nursing home use.
- Many nursing home residents with low care needs can be, and would prefer to be, served in the community. If all states achieved the rate found in Maine, 163,441 nursing home residents with low care needs would instead be able to receive LTSS in the community.
- Excessive transitions between care settings such as nursing homes and hospitals reflect poor coordination of services and are correlated with poor quality of care. If all states matched the performance of Minnesota, 120,602 hospitalizations could be avoided, saving an estimated $1.3 billion in health care costs.

Key Findings on Select Indicators and Public Policy Actions to Improve Performance

The *Scorecard* is a tool to help states improve their LTSS systems. The key findings that follow illustrate areas in which there is a large range in state performance and examples of how public policy action can lead to improvement.

Medicaid safety net

The *Scorecard* finds great variation in the percentage of the low- and moderate-income population with a disability in activities of daily living (ADLs) that is covered by the Medicaid LTSS safety net. In a typical month, the top five states provide Medicaid LTSS to 63 percent of this population. By contrast, in the bottom five states, coverage averages just 20 percent—less than a third of the rate in the top states. The national average is 37 percent.

Policy action: States have substantial control over establishing financial eligibility standards for Medicaid coverage. States also have great flexibility to determine the level of disability needed to qualify for services.

LTSS "balancing"

The five highest performing states on the proportion of Medicaid and state general revenue LTSS spending for older people and adults with physical disabilities going toward HCBS spend, on average, 60 percent of their dollars on HCBS. The average proportion of spending across the United States is 37 percent, and the five lowest performing states devote just 13 percent of Medicaid LTSS spending (for older people and adults with physical disabilities) to HCBS. Relatively few states "balance" spending, that is, spend more than half of their LTSS dollars for HCBS. *The extent of such balancing in the top states is nearly five times as high as in the bottom states.*

Policy action: This is an area over which state governments have tremendous control and, through their public policies, can make considerable strides in ensuring that people who need LTSS can choose noninstitutional options for care. States that have improved the balance of services away from institutions and toward HCBS have taken advantage of Medicaid "optional" services such as HCBS "waivers" and the Personal Care Services option. States also can pursue new opportunities offered by the *Patient Protection and Affordable Care Act* to improve the balance of their LTSS systems.

Maximizing consumer choice of LTSS options

The *Scorecard* finds a threefold difference between the five top- and bottom-performing states in the percentage of new Medicaid beneficiaries who receive HCBS before receiving any nursing home services. This indicator measures the LTSS system's ability to serve people in the community rather than a nursing home when they need support. In the top five states, on average, 77 percent of new Medicaid LTSS beneficiaries receive HCBS. By contrast, in the bottom five states, only 26 percent of new LTSS beneficiaries receive HCBS. The average across all states is 57 percent. Failing to serve new beneficiaries in HCBS settings can have negative impacts for an extended duration: those who enter a nursing home have a more difficult time returning to the community, even if they can and want to live in the community.

Policy action: State policies such as "options counseling" and nursing home diversion programs can help to direct new LTSS users

toward HCBS rather than nursing homes. States also can implement "presumptive eligibility" procedures to quickly establish that a person will be able to qualify for public support for HCBS, thereby preventing unnecessary nursing home admissions.

Consumer direction

The *Scorecard* finds wide variation in the extent to which state systems allow program participants to direct their own services. Variously referred to as consumer direction, participant direction, or self-direction, this model allows the individual to hire and fire a worker he or she chooses, set the hours for service delivery, and, in some cases, determine the wages paid.[3] Over the past several decades, self-direction has proven to be increasingly popular with many participants. The *Scorecard* finds that California was the highest ranking state, reporting 143 people receiving self-directed services per 1,000 adults with disabilities, or about 1 in 7. The average in the next four top-performing states was 51 people per 1,000 adults with disabilities. The national average was 22 people per 1,000 adults with disabilities. In each of the six lowest performing states, fewer than 1 out of every 1,000 adults with disabilities received self-directed services.

Policy action: States have great flexibility to give people who use LTSS the option to direct their own services in publicly funded programs. These programs often allow participants to have greater flexibility as to when services are delivered and who provides them. Such programs also can expand the available workforce, as many participants choose to hire family members who would not otherwise be working in this field.

Nursing home residents with low care needs

The *Scorecard* finds a tremendous range in the percentage of nursing home residents with low care needs. Because the national trend is that people with low care needs receive services in the community, states with a relatively high proportion of nursing home residents with low care needs may be offering an inadequate array of alternatives to nursing homes. In the five top-performing states, only 5 percent of long-stay nursing home residents had low care needs. By contrast, in the bottom five states, the proportion of nursing home residents with low care needs averaged 22 percent; more than four times the rate in the highest performing states.

Policy action: Taking advantage of federal grants such as Money Follows the Person can help states to move nursing home residents who want to return to the community into their own homes or apartments.

Pressure sores among nursing home residents

A key indicator of LTSS quality is the percentage of high-risk nursing home residents who develop pressure sores, a condition that is preventable with good-quality care. The *Scorecard* finds that the bottom five states have more than twice the level of long-stay nursing home residents with pressure sores, compared with the top five states: 16 percent compared with 7 percent.

Policy action: States have the responsibility to establish and enforce high standards for providers and effectively monitor the quality of care nursing homes provide. Every state is funded to operate a nursing home ombudsman program, but each state can determine how frequently the ombudsmen visit each facility, how they respond to complaints, and the

methods they use to monitor quality. State nursing home inspectors have a major role in enforcing federal directives to reduce pressure sores, and states can use quality bonuses to reward providers who demonstrate significant progress.

Preventing hospitalizations

Another indicator of LTSS quality, both in nursing homes and among home health patients, is the rate of hospitalizations. People who are receiving appropriate primary care and whose medical care is well coordinated with other services and supports should have fewer hospitalizations. States that do a better job of monitoring the quality of nursing home and home health care will reduce unnecessary hospital stays and, thus, achieve lower costs. The *Scorecard* finds that the bottom-performing states had, on average, three times the rate of hospitalization of long-stay nursing home residents compared with the top states: 29 percent compared with 10 percent.

Better quality of care can be cost-effective as well. For example, there is a strong correlation between occurrence of pressure sores and hospital admissions among long-stay nursing home residents (see Exhibit 15, p. 48). This finding is important for two reasons. Pressure sores are preventable with high quality of care and can result in serious, life-threatening infections in people who develop them. In addition, transitions between settings (e.g., nursing home to hospital), especially those that are caused by poor quality care, are both costly and often traumatic for LTSS users and their family caregivers. Though the variation is less dramatic, hospitalization rates among home health patients in the bottom five states averaged 37 percent, compared with 23 percent among the top five states.

Policy action: Some states are beginning to develop more coordinated service delivery systems that integrate primary, acute, chronic, and long-term services. Integrated approaches such as the Program of All-Inclusive Care for the Elderly (PACE) have a proven record of improving outcomes and reducing the use of institutions.

Nurse delegation

State Nurse Practice Acts usually determine the extent to which direct care workers can provide assistance with a broad range of health maintenance tasks.[4] For this *Scorecard,* we asked the National Council of State Boards of Nursing about state practices in delegating 16 specific tasks, including administration of various types of medications, ventilator care, and tube feedings. The five top-performing states allowed all 16 tasks to be delegated, whereas the bottom six states allowed none to be delegated. The median number of tasks that states allowed nurses to delegate was 7.5. Lower ranked states can learn from the top performers that delegation of these tasks to direct care workers is possible and supports consumers' choice to live in homelike settings.

Policy action: State policy directly determines what health-related tasks can be delegated. Unlike some policy changes that may cost states money and are therefore more challenging to implement, changing nurse practice laws will, if anything, save money in public programs by broadening the type of workers who can safely perform these tasks.

Conclusion

The *Scorecard* finds wide variation across all dimensions of state LTSS system performance. Part of this variation is attributable to the fact that the United States does not have a single unified approach to the provision of LTSS. The primary public program that funds LTSS is Medicaid: a federal-state partnership that gives states substantial flexibility to determine who is eligible for LTSS, how LTSS are accessed, what services will be provided, what the payment rates will be, and where services will be delivered. This flexibility provides opportunities to learn from creative approaches to delivering services yet results in disparities in the support available to frail older people and low-income people with disabilities. But there is also a need to learn from successful states so that the health and independence of people who need LTSS are not at risk because of their state of residence.

The *Affordable Care Act* offers states promising new incentives for improving their LTSS systems, and the lowest performing states have the most to gain by taking advantage of these new provisions. Reforms offer the opportunity to raise the bar for all states, particularly states that are lagging behind, to achieve the vision stated in legal and public policy goals. The Supreme Court in the 1999 *Olmstead* decision affirmed the right of people with disabilities to live in the least restrictive environment appropriate to their needs.[5] States that provide limited HCBS options through their Medicaid programs, do not provide sufficient information about or facilitate access to HCBS options, do not offer enhanced support to family caregivers, or do not effectively use home care workers to perform health maintenance tasks can learn from leading states that doing so can be cost-effective as well as responsive to the needs and preferences of older adults and people with disabilities.

Geography should not determine whether people who need LTSS have a range of choices for affordable, high-quality services. All Americans should share a unified vision that supports the ability of older people to have choices, and to be able to age in their own homes with dignity and the support they need to maximize their independence. The lives of people with disabilities should be integrated into the community, where they can maintain social connections, engage productively through employment or other meaningful activities, and contribute to the rich diversity of American life.

Building an improved system is possible and must begin now: the successes achieved by leading states have already shown the way. It is time to raise expectations for LTSS performance. We must move to become a nation in which older people and those with disabilities are given meaningful choices, have access to affordable, coordinated services, a high quality of life and care, and support for their family caregivers regardless of the state they live in.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AARP Wisconsin Supports SB 212/AB 302

AARP Wisconsin supports the revisions of the nursing home regulations set forth in SB212/AB302. We believe that the better coordination of the state and federal violation enforcement will provide greater protection to the frail elderly who live in nursing homes.

Too often these nursing home patients are unable to provide for their own care and safety and need to rely on the prompt and diligent enforcement of the standards by the regulatory agencies. Consequences for poor and life threatening behaviors must be real and must be meaningful. This bill provides the state with the means to keep the nursing home residents safe with a meaningful array of enforcement tools to make them safe

While most nursing homes provide excellent care, the outliers who do not provide a safe level of care, represent a very real threat to the very lives of our seniors. Having a strong system in effect that coordinates the regulatory functions of the state and federal government should reduce the preventable deaths and injuries to our very vulnerable populations.

We support this legislation because we believe it will help insure a safe and healthy environment for those needing to reside in nursing homes.

If you have question or comments about this position or any other position taken by AARP Wisconsin contact Helen Marks Dicks, Associate Director for State Advocacy 608-286-6337, hmdicks@aarp.org.

WHCA/WiCAL

To: Members of the Senate Committee on Public Health, Human Services, and Revenue & Members of the Assembly Committee on Aging and Long-Term Care

From: Jim McGinn, Director of Government Relations, WHCA/WiCAL
Brian R. Purtell, Director of Legal Services, WHCA/WiCAL

RE: 2011 Assembly Bill 302/Senate Bill 212

Date: October 13, 2011

The Wisconsin Health Care Association and the Wisconsin Center for Assisted Living (WHCA/WiCAL), an association including 170 of Wisconsin's nursing home providers, fully supports and endorses AB-302/SB-212, also known as the "Strengthening Our Nursing Homes Act," and hopes the Senate and Assembly Committees to which this legislation has been referred will look favorably upon this important legislation.

WHCA/WiCAL has advocated for reform of the duplicative and outdated nursing home enforcement process for years. This is not an effort to eliminate any regulations, expectations, or obligations on behalf of nursing home providers, rather, it is an effort to rectify the counterproductive system under which Wisconsin nursing home providers are penalized under both federal and state enforcements systems for the exact same circumstance.

This "dual enforcement" system is overly punitive, and due to its heavy reliance on financial penalties, is extracting needed financial resources from the providers that would otherwise be available to be put toward the care and treatment of the residents they are proud to serve. The major provisions of the bill and the basis for WHCA/WiCAL's support are further explained below.

1. **Modification to the current policy of state and federal citations for the same alleged deficient practice.**

Under current law, nursing homes are subject to both state and federal citations and sanctions for the same instance of alleged noncompliance. WHCA/WiCAL understands and appreciates the DHS requirement that it must issue federal deficiencies, as these are required conditions of participation in the Medicare and Medicaid programs. However, the issuing of an additional state citation for the exact same deficient practice is overly punitive, counterproductive, and often inhibits rather than promotes quality improvement.

This double-penalty system is the result of Wisconsin having adopted regulation and oversight of nursing homes long before the development and passage of federal enforcement regulations. Upon the final implementation of the federal enforcement system, Wisconsin left in place the

state enforcement system, leaving a process in which the exact same alleged noncompliance is subject to penalties under both federal and state enforcement processes. It is time to recognize that double punishment for the same circumstance is both inequitable, and contrary to the provision of quality of care. It is particularly important given the heavy reliance on financial penalties as the means for both state and federal enforcement, as we surely do not need to remind committee members of the increased financial challenges in light of current budgets on the Medicaid side, and recent and anticipated cuts to the Medicare program.

This bill does not, nor is WHCA/WiCAL advocating for, repeal of any regulation or expectation. This bill simply eliminates the potential for being assessed for a double penalty for a single incident of alleged non-compliance. The bill, in fact, expands DHS authority by allowing the Department to cite federal deficiencies, as well as state citations, as grounds for state licensure actions.

2. **Quality Improvement Fund.**

This bill makes modifications to Chapter 50 that would put into statute the development of a Quality Improvement Committee that would be responsible for distributing those funds that are currently returned to the DHS as a portion of the federal financial penalties imposed against providers. For several years the DHS has operated a committee that is responsible for distributing funds that are returned to the state. There are specific restrictions on how the federal government permits these funds to be used. Specifically, they must be used for quality improvement in nursing homes. This bill puts into statute the obligation that such efforts would continue.

WHCA/WiCAL strongly supports the statutory recognition of the CMP Committee and this bill would put into statute and solidify the existence of this Committee.

3. **Modifications of appeal deadlines.**

As identified in the 2002 Legislative Audit Bureau report on long-term care, the current 10-day deadline for nursing home providers to submit an appeal of a state citation or a state forfeiture is insufficient, and frankly, likely contributes to an increase in filings due to the providers not having sufficient time to analyze these citations. Given the many tasks that must be performed by a provider during the 10 days after receipt of the notice of violations, many providers simply submit an appeal so as to protect their right to do so. The modification in this bill that moves the deadline from 10 to 60 days will allow greater time to reflect on whether a provider should truly submit an appeal, rather than simply submitting a prophylactic response. The modification also aligns the appeal deadline with that under federal law.

Conclusion

WHCA/WiCAL hope the Committee will recognize the value of this legislation and recommend AB-302/SB-212 for passage.